Medical History Form

Please complete the following questions for your patient.

1. Age *(Write in)*

__ __ years old

2. Sex *(Check one)*

Male
Female

3. Body Mass Index *(Write in & check units)*

Height _____ ft / in
cm

Weight _____ lbs
kg

4. Ethnicity — Spanish, Hispanic or Latino?

Yes
No

5. Race *(Check one or more boxes)*

White
Black or African American
American Indian or Alaskan Native
Asian
Native Hawaiian or Other Pacific Islander
Don't know

6. Current medications *(List all medications–prescription and over-the-counter)*

1.	_____ name	_____ dose	6.	_____ name	_____ dose
2.	_____ name	_____ dose	7.	_____ name	_____ dose
3.	_____ name	_____ dose	8.	_____ name	_____ dose
4.	_____ name	_____ dose	9.	_____ name	_____ dose
5.	_____ name	_____ dose	10.	_____ name	_____ dose